

Bureau of Health Care Quality and Compliance

| | | | | | |
|---|---|--|--|--------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN6316HIC | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 05/16/2011 |
| NAME OF PROVIDER OR SUPPLIER VISTA ADULT CARE III | | | STREET ADDRESS, CITY, STATE, ZIP CODE 7300 PAH RAH DR SPANISH SPRINGS, NV 89436 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | |
| H 000 | <p>Initial Comments</p> <p>This Statement of Deficiencies was generated as a result of an initial State Licensure survey conducted in your facility on 5/16/11. This State Licensure survey was conducted by authority of NAC 449, Homes for Individual Residential Care, adopted by the State Board of Health on November 29, 1999.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The census at the time of the survey was zero. Zero resident files were reviewed and two employee files were reviewed.</p> <p>No regulatory deficiencies were identified. Please keep a copy of this statement for your records. No further action is required.</p> | H 000 | | | |

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE